DRUG MEDI-CAL ALCOHOL AND OTHER DRUG TREATMENT SERVICES

ARTICLE I. FORMATION AND PURPOSE

A. Exhibit D of this Contract is entered into by and between the State and the Contractor for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for alcohol and other drug (AOD) treatment in the Contractor's service area pursuant to Sections 11848, 11848.5(a) and (b), and 11758.40 through 11758.47 of the Health and Safety Code (hereinafter referred to as HSC), Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1 and consistent with the Interagency Agreement between the Department of Health Care Services (DHCS) and the State.

B. It is further agreed that Exhibit D of this Contract is controlled by applicable provisions of: (a) the Welfare and Institutions Code (hereinafter referred to as W&IC), Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14021, 14021.5, 14021.6, 14043, et seq. and 14132.90; (b) the HSC, in particular but not limited to, Sections 11758.40 through 11758.47; (c) Title 22, including but not limited to Sections 51490.1, 51341.1 and 51516.1; and (d) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

C. It is understood and agreed that nothing contained in Exhibit D shall be construed to impair the single state agency authority of DHCS.

D. The objective of Exhibit D is to make AOD treatment services available to Medi-Cal beneficiaries through utilization of federal funds available pursuant to Title XIX of the Social Security Act for reimbursable covered services rendered by certified DMC providers.

ARTICLE II. DEFINITIONS

The words and terms of this Contract are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 9, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference. The following definitions shall apply to Exhibit D of this Contact:

A. **"Administrative Costs"** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, program review, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Circular A-87. Contractor's indirect costs shall not be distributed to Subcontractors.

B. **"Beneficiary**" means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the "Diagnostic and Statistical Manual of Mental Disorders III Revised (DSM)," and/or DSM IV criteria; and (d) meets the admission criteria to receive DMC covered services.

C. **"Contractor"** means the county identified in the Standard Agreement or the department authorized by that county's Board of Supervisors to administer alcohol and drug programs.

D. **"Covered Services"** means those DMC services authorized by Title XIX of the Social Security Act; Title 22 Section 51341.1; HSC Section 11758.46; and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug-free treatment, narcotic replacement therapy, day care rehabilitative (for pregnant, postpartum, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries only), and perinatal residential AOD treatment (excluding room and board).

E. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified AOD treatment providers who are reimbursed for those services with a combination State General Fund (SGF) and federal Medicaid funds.

F. **"Early and Periodic Screening, Diagnosis, and Treatment Program"** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries under 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

"Early and Periodic Screening, Diagnosis, and Treatment Program (Supplemental Service)" means the supplemental individual outpatient drug-free (ODF) counseling services provided to beneficiaries eligible for the EPSDT program. Supplemental individual ODF counseling consists of any necessary individual AOD counseling not otherwise included in the ODF counseling modality under the DMC program.

G. **"Federal Financial Participation (FFP)"** means the share of federal Medicaid funds for reimbursement of DMC services.

H. **"Final Settlement"** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit has not begun within three years, the interim settlement shall be considered as the final settlement.

I. "**Interim Settlement**" means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

J. **"Medical Necessity"** means those AOD treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or, in the case of EPSDT, services that meet the criteria specified in Title 22, Section 51340.1.

K. **"Minor Consent DMC Services"** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.

L. "**Narcotic Treatment Program (NPT)"** means an outpatient clinic licensed by the State to provide narcotic replacement therapy using methadone directed at stabilization and rehabilitation of persons who are opiate-addicted and have an AOD diagnosis.

M. **"Perinatal DMC Services"** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

N. **"Postpartum,"** (as defined for DMC purposes) means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.

O. "**Postservice Postpayment (PSPP) Utilization Review"** means the review for program compliance and medical necessity conducted by the State after service was rendered and the claim paid. State may recover prior payments if such review determines that the services did not comply with the applicable statutes, regulations, or standards.

P. **"Projected Units of Service"** means the number of reimbursable DMC units of service, based on historical data and current capacity, Contractor expects to provide on an annual basis.

Q. **"Protected Population"** means: (1) EPSDT-eligible Medi-Cal beneficiaries under age 21; and (2) Medi-Cal-eligible pregnant and postpartum women.

R. **"Provider of DMC Services"** means any person or entity that provides direct AOD treatment services and has been certified by State as meeting the standards for participation in the DMC program set forth in the "DMC Certification Standards for Substance Abuse Clinics", Document 2E and "Standards for Drug Treatment Programs (October 21, 1981)", Document 2F.

S. **"Satellite site"** has the same meaning as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.

T. "**Service Area"** means the geographical area under Contractor's jurisdiction.

U. **"Statewide Maximum Allowances (SMA)"** means the maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Rates are subject to change annually. The SMA for FY 2007-08 is listed in the "Unit of Service" table in this Article II, Section Y.

V. **"Subcontract"** means an agreement between the Contractor and its Subcontractors. A Subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/client services.

W. **"Subcontractor"** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a direct provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit D.

X. **"Uniform Statewide Monthly Reimbursement (USMR) Rate"** means the rate for NTP services based on a unit of service that is a calendar month of treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The following table shows the Fiscal Year (FY) 2007-08 USMR.

Service	Type of UOS	Non-perinatal UOS (*)	Perinatal UOS (*)	Rate
NTP-Methadone	Daily	$11.20 1.02 (*)-	$12.15 1.11 (*)	Maximum
	Monthly	$340.67	$369.56-	
NTP-Individual Counseling (**)	One 10-minute increment	$14.96 1.37 (*)-	$21.22 1.94 (*)	Maximum
NTP Group Counseling (**)	One 10-minute increment	$3.51 0.32 (*)	$7.07 0.65 (*)	Maximum

(*) Administrative Costs incorporated within the rate.

(**) The NTP Subcontractors may be reimbursed for up to 200 minutes (20 10-minute increments) of individual and/or group counseling per calendar month per beneficiary.

Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USMR. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual patient/client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A)).

Y. **"Unit of Service"** means a face-to-face contact on a calendar day for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Only one face-to-face service contact per day is covered by DMC except in the case of emergencies when an additional face-to-face contact may be covered for intake crisis intervention or collateral service. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and each contact shall be clearly documented in the beneficiary's record. Units of service and SMA for FY 2007-08 are:

Service	Type of Unit of Service (UOS)	Non-perinatal UOS	Perinatal UOS	Rate
Day Care Rehabilitative	Face-to-Face Visit	$67.55 for EPSDT only	$79.92	Statewide Maximum Allowance
Naltrexone Treatment	Face-to-Face Visit	$21.19	N/A	Statewide Maximum Allowance
Outpatient Drug-Free Treatment	Face-to-Face Individual Group	$74.79 $31.56	$106.08 $63.62	Statewide Maximum Allowance
Perinatal Residential	Residential Day	N/A	$96.81	Statewide Maximum Allowance

ARTICLE III. PROVISION OF SERVICE

A. Covered Services

1. Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for covered services in the Contractor's service area. Covered services include:

   (a) Outpatient drug-free treatment;

   (b) Narcotic replacement therapy;

   (c) Naltrexone treatment;

   (d) Day care rehabilitative (pregnant or postpartum, and EPSDT only); and,

   (e) Perinatal residential AOD treatment services (excluding room and board).

2. In the event of a conflict between the definition of services contained in this Exhibit D and the definition of services in Sections 51341.1, 51490.1, and 51516.1 of Title 22, the provisions of Title 22 shall govern.

B. Federal and State Mandates

1. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

2. Contractor shall comply with any additional legal requirements including, but not limited to, any court-ordered requirements and statutory or regulatory amendments to existing law (including changes in covered services) that are imposed or are effective subsequent to the execution of this Contract. Contractor agrees that this Contract shall be amended to reflect such requirements, amendments, or changes.

3. Contractor shall comply with federal and state mandates to provide alcohol and other drug treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) youth under age 21 who are eligible under the EPSDT Program.

4. Contractor shall comply with the California Family Code Section 6929 in the provision of Minor Consent Medi-Cal Services.

5. Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services in its service area. Such services shall not be limited due to budgetary constraints.

   (a) When a request for covered services is made by a beneficiary, Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.

   (b) Contractor shall submit, and shall require its Subcontractors to submit, information required by the State. The information shall include, but is not limited to, data as required pursuant to the following:

   Document 1K: Drug and Alcohol Treatment Access Report (DATAR) in an electronic format as provided and/or approved by the State, which complies with the Department of Alcohol and Drug Programs (ADP) compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method. Effective July 1, 2007, the format for submission shall be limited to electronic format only.

   Document 3J: California Outcomes Measurement System (CalOMS) Treatment records – Submit CalOMS treatment admission, discharge, annual update, or "provider no activity report" records in an electronic format provided and/or approved by the State, which complies with ADP compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and report method. Meet re-certification requirements whenever there are substantial changes to the Contractor's CalOMS Treatment system.

   (c) Contractor agrees that it shall submit all data requested in (a) and (b) in a manner identified, or on forms provided, by the State by the applicable due dates or the dates in Document 1F, "Matrix of Documents, Reports and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs."

(d) Contractor shall require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

6. Covered services, whether provided directly by the Contractor or through subcontractors with DMC certified programs, shall be provided to beneficiaries without regard to the beneficiaries' county of residence.

7. In the event Contractor fails to comply with subdivisions 1 through 6 of this Section, the State may terminate this Contract for cause.

8. Contractor shall notify the State in writing prior to reducing the provision of covered services. In addition, any proposal to change the location where covered services are provided, or to reduce their availability, shall be submitted in an application to the State sixty (60) days prior to the proposed effective date. Contractor shall not implement the proposed changes if the State denies the Contractor's proposal.

9. Contractor shall amend its subcontracts for covered services in order to provide sufficient DMC SGF to match allowable federal Medicaid reimbursements for any increase in provider DMC services to beneficiaries.

10. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

11. In the event that the Contractor fails to provide covered services in accordance with the provisions of this Contract, at the discretion of the State, Contractor may be required to forfeit its DMC SGF allocation and surrender its authority to function as the administrator of covered services in its service area.

12. The failure of the Contractor or its Subcontractors to comply with Section B of this Article will be deemed a breach of this Contract sufficient to terminate this Contract for cause. In the event the Contract is terminated, the provision of Exhibit B, Paragraph G, subsections 2, 3, and 4 shall apply.

C. Provider Participation, Certification, Recertification, and Appeals

1. State will review and certify eligible providers to participate in the DMC program. Certification agreements will not be time limited. State will conduct recertification on-site visits at clinics for circumstances identified in the "Drug Medi-Cal Certification Standards for Substance Abuse Clinics", (Document 2E). Document 2E contains the appeal process in the event the State disapproves a provider's request for certification or recertification and shall be included in the Contractor's subcontracts.

2. Contractor shall include a provision in its subcontracts informing the provider that it may seek assistance from the State in the event of a dispute over the terms and conditions of subcontracts.

3. Contractor shall require all the providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:

   (a) Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;

   (b) Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Document 2E);

   (c) Title 22, Sections 51341.1, 51490.1, and 51516.1, (Document 2C);

   (d) Standards for Drug Treatment Programs (October 21, 1981) (Document 2F); and

   (e) Title 9, Sections 10000, et seq.

   In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

   Contractor acknowledges that if a provider is under investigation by DHCS or any state, local or federal law enforcement agency for fraud or abuse, the State may temporarily suspend the provider from the DMC program, pursuant to W&IC Section 14043.36(a).

   Contractor and Subcontractors shall participate in DMC orientation training sessions as prescribed by the Department.

4. If, at any time, a Subcontractor's license, registration, certification, or approval to operate an AOD treatment program or provide a covered service is revoked, suspended, modified, or not renewed, the State may amend this Contract.

   A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

ARTICLE IV. FISCAL PROVISIONS

A. Reimbursements

To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Contract, the State agrees to pay the Contractor DMC SGF and federal Medicaid funds according to Article V. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds for allowable expenditures as established by the federal government and approved by DHCS, for the cost of services rendered to beneficiaries.

1. Reimbursement for covered services shall be made in accordance with applicable provisions of Title 22 and all other currently applicable policies and procedures.

2. It is understood and agreed that failure by the Contractor or its Subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the Contractor. If the State, DHCS, or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to the State the federal Medicaid funds and SGF it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

   Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a). This requirement does not apply to the DMC PSPP Utilization Reviews.

   The State shall refund to the Contractor any recovered Drug Medi-Cal overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Title 22, CCR, Section 51047(e).

3. This Contract encumbers a specific amount of DMC SGF to be used in accordance with the Contractor's allocation as described in the State's final allocation notice. This amount is intended to cover all anticipated need for DMC SGF covered services. If the need for allowable DMC services is less than anticipated in any particular fiscal year, the State may reduce the contract amount of DMC SGF through a contract amendment, the cost settlement process, or other available processes. If, during the term of this Contract, Contractor’s cost for allowable DMC services is anticipated to exceed the maximum amount allowed for services described in Exhibit D, and the Contractor anticipates utilizing all available DMC SGF allocated for the

State match, Contractor shall submit a written request by submission of a budget to the State for additional DMC SGF funding.

4. Contractor shall use DMC SGF without DMC FFP to fund Drug Medi-Cal services to clients eligible for those services but not eligible for federal funding under Title XIX of the Social Security Act (42 U.S.C. Ch. 7, Subch. XIX).

B. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit D. Any federal Medicaid funds and DMC SGF paid to the Contractor, but not expended for DMC services shall be returned to the State.

C. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Contract may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Contract was not executed until after that determination. If so, State may amend the amount of funding provided for in this Contract based on the actual congressional appropriation.

D. Additional Restrictions

This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

E. Amendment or Cancellation Due to Insufficient Appropriation

This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purpose of the DMC program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this program, State has the option to void this contract or to amend the Contract to reflect any reduction of funds.

F. Exemptions

Exemptions to the provisions of Section E, above, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the contract.

G. Payment for Covered Services

Any payment for covered services rendered pursuant to this Exhibit D shall only be made pursuant to applicable provisions of Title XIX of the Social Security Act; the W&IC; the HSC; California's Medicaid State Plan; and Sections 51341.1, 51490.1, 51516.1, and 51532 of Title 22.

1. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, including any allowable county administrative costs, not to exceed the unit of service maximum rate.

   Pursuant to HSC Section 11758.42 (h), reimbursement to NTP providers shall be limited to the lower of either the uniform statewide monthly reimbursement rate, or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a Contractor to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A).)

2. Pursuant to HSC Section 11818(b)(2), Contractor shall reimburse providers that receive a combination of Medi-Cal funding and other federal or state funding for the same service element and location based on the provider's actual costs in accordance with Medi-Cal reimbursement requirements as specified in Title XIX of the Social Security Act; Title 22, and the state's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.

H. Allowable Costs

Allowable costs, as used in Section 51516.1 of Title 22 shall be determined in accordance with Title 42, CFR Parts 405 and 413, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov." In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for Medi-Cal administrative activities.

I. Records and Additional Audit Requirements

1. Accurate fiscal records and supporting documentation shall be maintained by the Contractor and its Subcontractors to support all claims for reimbursement. All records must be capable of verification by auditors.

2. Should a Subcontractor discontinue operations, Contractor shall retain the Subcontractor's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records retaining to state funds. Contractor shall follow SAM requirements.

   If the Contractor cannot physically maintain the fiscal and program records of the Subcontractor, then arrangements shall be made with the State to take possession and maintain all records.

3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the Bureau of State Audits has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not begun within three years, the interim settlement shall be considered as the final settlement.

   Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government, the State, or DHCS has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all audit issues.

4. In addition to the audit requirements set forth in Exhibit B, State may also conduct financial audits of DMC programs, exclusive of NTP services provided on or after July 1, 1997, to accomplish any of, but not limited to, the following audit objectives:

   (a) To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

   (b) To ensure that only the cost of allowable DMC activities are included in reported costs;

   (c) To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov, for comparison to the DMC cost per unit;

   (d) To review documentation of units of service and determine the final number of approved units of service;

(e) To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,

(f) To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

5. In addition to the audit requirements set forth in Exhibit B, State may conduct financial audits of NTP programs. For NTP services on or after July 1, 1997, the audits will address items 4(c) through 4(e) above, except that the comparison of the provider's usual and customary charge in 4(c) will be to the DMC USMR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:

(a) For those NTP providers required to submit a cost report pursuant to HSC Section 11758.46(j)(2), a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;

(b) A review of actual costs incurred for comparison to services claimed;

(c) A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;

(d) A review of the number of clients in group sessions to ensure that sessions include no less than four and no more than ten clients at the same time, with at least one Medi-Cal client in attendance;

(e) Computation of final settlement based on the lower of USMR rate or the provider's usual and customary charge to the general public; and,

(f) A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

6. Audit reports by the State and/or DHCS shall reflect all findings and any recommendations, adjustments, or corrective action necessary as a result of those findings.

7. Contractor shall be responsible for any disallowances taken by the Federal Government, State, the State, the Bureau of State Audits, or DHCS as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds.

8. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within one year from the date of the plan.

9. Contractor, in coordination with the State, must provide follow-up on all significant findings in the audit report, including findings relating to a Subcontractor, and submit the results to the State.

10. If differences cannot be resolved between the State and/or DHCS and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit D, Contractor may request an appeal in accordance with the appeal process described in the "DMC Audit Appeal Process," Document 1J(b), incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

    Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process.

11. Providers of DMC services shall, upon request, make available to the State its fiscal and other records to assure that such provider has adequate recordkeeping capability and to assure that reimbursement for covered DMC services are made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

    (a) Provider ownership, organization, and operation;

    (b) Fiscal, medical, and other recordkeeping systems;

    (c) Federal income tax status;

    (d) Asset acquisition, lease, sale, or other action;

    (e) Franchise or management arrangements;

    (f) Patient service charge schedules;

(g) Costs of operation;

(h) Cost allocation methodology;

(i) Amounts of income received by source and purpose; and,

(j) Flow of funds and working capital.

12. In the event this Contract is terminated, Contractor shall deliver all of its fiscal and program records pertaining to the performance of this Contract to the State, which will retain the records for the required retention period.

13. Contractor shall retain records of utilization review activities required in Article VI herein for a minimum of three (3) years.

ARTICLE V. INVOICE/CLAIM AND PAYMENT PROCEDURES

A. Payments

1. State shall reimburse the Contractor:

   (a) The DMC SGF amount upon approval by DHCS of the DMC claims and reports submitted in accordance with Article 5 of Section B, below.

   (b) The federal Medicaid amount upon approval by DHCS of the DMC claims and reports submitted in accordance with Article 5 Section B, below.

   (c) The federal Medicaid and DMC SGF:

      i At either the USMR rate or the provider's usual or customary charge to the general public for NTP's; or,

      ii At a rate that is the lesser of the projected cost or the maximum rate allowance for other DMC modalities.

2. State will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov.

3. Contractors and Subcontractors must accept, as payment in full, the amounts paid by the State in accordance with Title 22, CCR, Section 51516.1, plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the client. However, Contractors and Subcontractors may not deny services to any client eligible for DMC services on account of the client's inability to pay or location of eligibility. Contractors and Subcontractors may not demand any additional payment from the State, client, or other third party payers.

B. Drug Medi-Cal Claims and Reports

1. Contractors or providers that invoice the State or the County for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with the DMC Provider Billing manual.

   (a) Claims shall be submitted electronically in the Health Insurance Portability and Accountability Act (HIPAA) 837 format.

   (b) All claims shall be accompanied by a Drug Medi-Cal Monthly Summary Invoice (ADP 1592), Document 2H.

   (c) When applicable, claims shall be accompanied by Provider Report of Drug Medi-Cal Claims Adjustment (ADP 5035C), Document 2J.

   Note: The following forms shall be prepared as needed and retained by the provider for review by State staff:

   - Multiple Billing Override Certification (ADP 7700), Document 2K

   - Good Cause Certification (ADP 6065), Document 2L

2. In the absence of good cause documented on the Good Cause Certification (ADP 6065) form, claims that are not submitted within 30 days of the end of the month of service shall be denied. The existence of good cause shall be determined by the State in accordance with Title 22, CCR, Sections 51008 and 51008.5.

3. Claims for reimbursement shall include only those services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&IC, Sections 14132.44 and 14132.47.

4. Contractor shall utilize the Drug Medi-Cal Provider Billing Manual (for a copy, please contact your ADP Fiscal Management and Accountability Analyst) and the Companion Guide for HIPAA 837P and 835 Transactions (Document 2Y) for understanding and obtaining instructions for the DMC billing process.

C. Year-End Cost Settlement Reports

1. State will not accept year-end cost settlement reports from the Subcontractor(s) directly. Pursuant to HSC Section 11758.46 (j)(2) Contractor shall submit to the State, on November 1 of each year, the following documents by paper or electronic submission for the previous fiscal year:

   (a) Document 2P, County Certification Year-End Claim for Reimbursement

   (b) Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Day Care Rehabilitative for Alcohol and Drug or Perinatal (if applicable)

(c) Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Alcohol and Drug or Perinatal (if applicable)

(d) Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Alcohol and Drug or Perinatal (if applicable)

(e) Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)

(f) Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs for Alcohol and Drug or Perinatal (if applicable)

(g) Electronic program as prescribed by the State that contains the detailed cost report data

2. State may settle costs for DMC services based on the year-end cost settlement report as the final amendment to the approved single State/County contract.

3. Reimbursement for covered services, other than NTP services, shall be limited to the lower of: (a) the provider's usual and customary charges to the general public for the same or similar services; (b) the provider's actual allowable costs; or (c) the DMC SMA for the modality.

4. Reimbursement to NTP's shall be limited to the lower of either the USMR rate, pursuant to HSC Section 11758.42(h)(1), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A)).

ARTICLE VI. POSTSERVICE POSTPAYMENT UTILIZATION REVIEW

A. State shall conduct Postservice Postpayment (PSPP) utilization reviews in accordance with Title 22 Section 51341.1. Any claimed DMC service may be reviewed for compliance with all applicable standards, regulations and program coverage after services are rendered and the claim paid.

B. State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate.

Contractor and/or Subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled pursuant to Title 22, CCR, Section 51015, in accordance with the Interagency Agreement between the State and DHCS. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Article IV, Division I, of this Contract.

C. State shall monitor the Subcontractor's compliance with PSPP utilization review requirements in accordance with Title 22. DHCS and the federal government may also review the existence and effectiveness of the State's utilization review system.

D. Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

E. Satellite sites must keep a record of the clients/patients being treated at that location. Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government, the State, or DHCS has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

LIST OF EXHIBIT D DOCUMENTS INCORPORATED BY REFERENCE*
FISCAL YEAR 2007-08

The following documents are hereby incorporated by reference into Exhibit D of the combined County contract though they may not be physically attached to the contract:

Document 1F:	Matrix of Documents, Reports, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs
Document 1H(a):	Service Code Descriptions
Document 1H(b):	Program Code Listing
Document 1J(b):	DMC Audit Appeal Process
Document 1K:	Drug and Alcohol Treatment Access Report http://www.adp.ca.gov/datar/gen_info.shtml
Document 1P:	Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)
Document 1W:	Certification Regarding Lobbying
Document 1X:	Disclosure of Lobbying Activities – Standard Form LLL
Document 2A:	Sobky v. Smoley, Judgment, Signed February 1, 1995
Document 2C:	Title 22, California Code of Regulations http://ccr.oal.ca.gov
Document 2E:	Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004) http://www.adp.ca.gov/dmc/pdf/DMCA_Drug_Medi-Cal_Certification_Standards.pdf
Document 2F:	Standards for Drug Treatment Programs (October 21, 1981) http://www.adp.ca.gov/dmc/pdf/DMCA_Standrds_for_Drug_Treatment_Programs.pdf
Document 2H:	Drug Medi-Cal Monthly Summary Invoice (ADP 1592)
Document 2J:	Provider Report of Drug Medi-Cal Claims Adjustments (ADP 5035C) – Form/Instructions

Document 2K:	Multiple Billing Override Certification (ADP 7700)
Document 2L:	Good Cause Certification (ADP 6065)
Document 2P:	County Certification - Cost Report Year-End Claim For Reimbursement
Document 2P(a):	Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Alcohol and Drug (forms and instructions)
Document 2P(b):	Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Perinatal (forms and instructions)
Document 2P(c):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Alcohol and Drug (forms and instructions)
Document 2P(d):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Perinatal (forms and instructions)
Document 2P(e):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Alcohol and Drug (forms and instructions)
Document 2P(f):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Perinatal (forms and instructions)
Document 2P(g):	Drug Medi-Cal Cost Report Forms – Residential – Perinatal (forms and instructions)
Document 2P(h):	Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Alcohol and Drug (forms and instructions)
Document 2P(i):	Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Perinatal (forms and instructions)
	http://www.adp.ca.gov/ADPLTRS/97-52.shtml
Document 2Y:	Companion Guide for HIPAA 837P and 835 Transactions
	http://www.adp.ca.gov/hp/hipaa.shtml
Document 3E	ADP Bulletin #05-03 – HIPAA Drug Medi-Cal Claim Submission Policy
	http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_05-03.pdf
Document 3F	ADP Bulletin #05-10 – Acceptable Drug Medi-Cal Claim Format for Processing
	http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_05-10.pdf

Document 3G	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs http://www.calregs.com
Document 3H	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors http://www.calregs.com
Document 3J	CalOMS Treatment Data Collection Guide http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Collection_Guide_2007-05.pdf
Document 3K	Business Associate Agreement: County is the Business Associate of the Department of Alcohol and Drug Programs